Macon County Schools
Emergency Action Plan for Food Allergies

PLEASE NOTE: BOTH SIDES OF THIS FORM MUST BE COMPLETED BY PARENT AND MD IF CHILD HAS FOOD ALLERGY

ALLERGY TO: ________________________________

Student's Name: ________________________________ Date of Birth: _____________ School: ______________

Teacher:____________________ Asthmatic: Yes*________ No________ * High risk for severe reaction

SIGNS OF AN ALLERGIC REACTION INCLUDE:

Systems:	**Symptoms:**
* **MOUTH**	itching and swelling of the lips, tongue, or mouth
* **THROAT***	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
* **SKIN**	hives, itchy rash, and/or swelling about the face or extremities
* **GUT**	nausea, abdominal cramps, vomiting, and/or diarrhea
* **LUNG***	shortness of breath, repetitive coughing, and/or wheezing
* **HEART***	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation!

EMERGENCY ACTION PLAN:

1. If ingestion is suspected, give ________________________________ and__________________________ IMEDIATELY!
   Medication/dose/route
2. CALL 911!
3. CALL Mother at: _____________________ Father at: ____________________ Other at:________________
4. CALL Dr. ________________________ at _________________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911 EVEN IF PARENTS OR DOCTOR CANNOT BE REACHED!

__________________________ _____________ __________________________ _________

Parent Signature Date MD Signature Date

EMERGENCY CONTACTS	**TRAINED STAFF MEMBERS**
1. ______________________________ **Relation:** ___________ **Phone:**__________________ **2.** ______________________________ **Relation:**__________________ **Phone:**_____________________	**1. Name:** ___________________________ **Grade:** ___________________ **2. Name:** ___________________________ **Grade:**______________________

FOR SCHOOL USE ONLY
Form received by: ________________________________ Date:_________________

Initial or Check below when completed:
Copy sent to: School Nurse:______ Child Nutrition Manager: ______ VIP/More@4:______
Teacher:______ CN Director: ______